

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL****FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

0 1 — 0 0 5

2. STATE:

GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

~~January 1, 2001~~ March 29, 2001

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.272

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 50,754,601

b. FFY 2002 \$ 67,672,801

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

ATTACHMENT 4.19-D, pp. 74

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

ATTACHMENT 4.19-D, pp. 74

10. SUBJECT OF AMENDMENT:

NURSING FACILITY SERVICES - UPPER PAYMENT LIMIT RATE ADJUSTMENTS

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ OTHER, AS SPECIFIED:☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Mark Trail

14. TITLE:

Acting Director, Division of Medical Assistance

15. DATE SUBMITTED:

16. RETURN TO:

Georgia Community Health  
Division of Medical Assistance  
2 Peachtree Street, N.W.  
Atlanta, Georgia 30303-3159

17. DATE RECEIVED:

March 29, 2001

18. DATE APPROVED:

December 28, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

March 29, 2001

21. TYPED NAME:

Eugene A. Grasser

20. SIGNATURE OF REGIONAL OFFICIAL:

22. TITLE Associate Regional Administrator  
Division of Medicaid and State Operations

23. REMARKS:

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –  
NURSING FACILITY SERVICES

For payments made for services provided on or after March 29, 2001, subject to the availability of funds in the year in which the interim and final rate is paid, State government-owned or operated facilities and non-State government owned or operated facilities will be eligible for rate payment adjustments. The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that, based on their status as government owned or operated, need sufficient funds for their commitments to meet the healthcare needs of all members of their communities. A facility's status as government owned or operated will be based on its ability to make direct or indirect intergovernmental transfer payments to the State. If sufficient funds are not available to provide maximum allowable payment amounts, rate adjustment payments may be reduced proportionally among facilities eligible to receive payment.

The rate payment adjustments will be subject to federal upper payment limits. For the appropriate groupings of State government-owned or operated facilities, non-State government owned or operated facilities and all other facilities, aggregate rate adjustment payments available without exceeding upper payment limits will be determined by measuring the difference between:

- Amounts paid for services provided to Medicaid patients and
- Estimated payment amounts for such services if payments were based on Medicare payment principles. Either cost based or rate payment measures may be used as Medicare payment principles.

Comparisons of amounts paid for services provided to Medicaid patients and estimated payment amounts for such services if payments were based on Medicare payment principles will also be made for each facility to determine facility-specific rate adjustment payments. These rate payment adjustments will be made on a monthly, quarterly or annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims.

An example of how a rate adjustment payment could be calculated is presented on the following page.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –  
NURSING FACILITY SERVICES

Facility Name		XYZ Nursing Home
1	Medicaid per diem rate as of April 1, 2001	\$78.56
FY2000 cost report data (or December 2000 occupancy and rate data if cost report data not available)		
2a	Days in Report Period	365
2b	Conversion Factor for Annual Period (365 / line 2a)	1.0000
2c	Medicaid Patient Days for Report Period	21,895
2d	Medicaid Patient Days for Annual Period (line 2b x line 2c)	21,895
<u>Transition from Facility Specific Rate to Medicare PPS Rate</u>		not applicable
3a	Facility specific rate per day for April 1, 2000	
3b	Portion of rate determined by facility specific basis	
3c	PPS rate per day for April 1, 2000	
3d	Portion of rate determined by PPS basis	
4	Average payment rate based on analysis of Medicare PPS rates as of April 1, 2000	\$176.05
5	Statewide average Medicaid payments per nursing home patient day for pharmacy, laboratory and radiology services	\$7.80
6	Average Medicare rate adjusted to match services covered by Medicaid rate (line 4 - line 5)	\$168.25
7	Average adjusted Medicare rate less Medicaid rate per day (line 6 - line 1)	\$89.69
8	Facility-specific upper payment limit calculation (greater of 0 or [line 2d x line 7])	\$1,963,763
9	Allocation of statewide aggregate limit on adjustment payments	\$0
10	Projected upper payment limit rate adjustment (line 8 + line 9)	\$1,963,763